NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAID CARE MANAGEMENT PROGRAM

REQUIREMENTS FOR ACCESS TO SERVICES AND NETWORK ADEQUACY

Consistent with federal law[1], the Medicaid Care Management Program requirements for access to services, including network adequacy standards described in the Agreement between the New Hampshire Department of Health and Human Services (DHHS) and each Managed Care Organization (MCO) are include below.[2,3]

1 Requirements for Adequate Access to Services

Each MCO must ensure adequate capacity to serve members in its statewide service area in accordance with the State's access requirements described in this section.

- The MCO shall:[4]
    - Have providers in sufficient numbers, and with sufficient capacity and expertise for all covered services to meet the Agreement's geographic standards, timely provision of services requirements, Equal Access, and reasonable choice by members to meet their needs.[5,6]
    - Offer an appropriate range of preventive, primary care, and specialty services and maintains an adequate network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area [42 CFR 438.207(b)]:
    - Make services available for members twenty-four (24) hours a day, seven (7) days a week, when medically necessary [42 CFR 438.206(c)(1)(iii)].
    - Require that all network providers offer hours of operation that provide Equal Access and are no less than the hours of operation offered to commercial, and FFS patients [42 CFR 438.206(c)(1)(ii)].

[1] 42 CFR 438.68 and 42 CFR 438.10(e)(2)(viii).
[2] These standards are based on those described in the Medicaid Care Management Agreement (Exhibit A, Amendment #16 available at http://sos.nh.gov/nhsos_content.aspx?id=8589977631), and are subject to change. In the event of discrepancies between this document and the Agreement, language in the Agreement/Amendment preside.
[3] Ibid., Section 20.2.1.
[4] Ibid., Section 20.4.
[5] Ibid., Section 20.1.2.
[6] "Equal Access" means Medicaid managed care members and NHHPP members have the same access to providers and services for those services common to both populations. [Ibid., Section 2; Ibid., Section 21.1 (in part).]

- Encourage its primary care physicians (PCP)s to offer after-hours office care in the evenings and on weekends.

- Ensure members have access to DHHS-designated Level I and Level II trauma centers within the State, or hospitals meeting the equivalent level of trauma care in the MCO's service area or in close proximity to such service area. The MCO shall have written out-of-network reimbursement arrangements with the DHHS-designated Level I and Level II trauma centers or hospitals meeting equivalent levels of trauma care if the MCO does not include such a trauma center in its network.[7]

- Ensure accessibility to other specialty hospital services, including major burn care, organ transplantation, specialty pediatric care, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, cranio-facial and congenital anomalies, home health agencies, hospice programs, and licensed long-term care facilities with Medicare-certified skilled nursing beds.[8]

- The MCO shall meet the following minimum timely access to services standards [42 CFR 438.206(c)(1)(i)]:[9]

  - The MCO shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

    - Transitional healthcare by a provider shall be available from a primary or specialty provider for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder (SUD) treatment program.

    - Transitional home care shall be available with a home care nurse or a licensed counselor within two (2) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a SUD treatment program, if ordered by the member's PCP, specialty care provider, or as part of the discharge plan.

    - Non-symptomatic (i.e., preventive care) office visits shall be available from the member's PCP or another provider within forty-five (45) calendar days. A non-symptomatic office visit may include, but is not

[7] Ibid., Section 20.7.1.
[8] Ibid., Section 20.7.2.
[9] Ibid., Section 20.4.4

limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

- Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the member's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs or symptoms not requiring immediate attention [but monitoring].

- Urgent, symptomatic office visits shall be available from the member's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.[10]

- Emergency medical, SUD and psychiatric care shall be available twenty-four (24) hours per day, seven (7) days per week.

- Behavioral health care shall be available as follows:

  - Care within six (6) hours for a non-life threatening emergency;
  - Care within forty-eight (48) hours for urgent care; or
  - An appointment within ten (10) business days for a routine office visit.

- Health care services shall be made accessible on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.[11]

- The MCO shall:

  - Provide female members with direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's

[10] "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 CFR 438.114(a)). [Ibid., Section 2.]

[11] Ibid., Section 20.4.4.1.

designated source of primary care if that source is not a women's health specialist [42 CFR 438.206(b)(2)].[12]

- Provide access to family planning services to members without the need for a referral or prior-authorization. Additionally, members shall be able to access these services by providers whether they are in or out of the MCO's network.[13]

- Provide for a second opinion from a qualified health care professional within the provider network, or arrange for the member to obtain one outside the network, at no greater cost to the member than allowed by DHHS [42 CFR 438.206(b)(3)].[14]

- If the MCO's network is unable to provide necessary medical, behavioral, and SUD services covered under the Agreement to a particular member, the MCO shall adequately and in a timely manner cover these services for the member through out-of-network sources [42 CFR 438.206(b)(4)].[15]

- For counseling or referral services the MCO does not cover because of moral or religious objections (currently, there are no reported services) as listed on the DHHS website, DHHS will provide information about where and how to obtain the service. Contact the NH DHHS Customer Service Center, Monday through Friday (except state holidays), 9:00 a.m. to 4:00 p.m. ET at **1-888-901-4999** (TTY/TDD: 1-800-735-2964).[16]

- The MCO shall participate in efforts to promote the delivery of services in a culturally and linguistically competent manner to all members and their families, including those with Limited English Proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. [42 CFR 438.206(c)(2)].[17]

- The MCO shall assure appropriate physical access to obtain included benefits for all members with a disability, including assurance of reasonable accommodations and accessible equipment for members with physical and mental disabilities [42 CFR 438.206(c)(3)].[18]

[12] Ibid., Section 20.5.1.
[13] Ibid., Section 20.5.2.
[14] Ibid., Section 20.9.1.
[15] Ibid., Section 20.8.1 (in part).
[16] Ibid., Sections 17.1.19-17.1.20.
[17] Ibid., Sections 16.2.4 and 18.2.1.
[18] Ibid., Sections 10.3.1.2 and 28.2.2.3.

2 Network Adequacy Standards[19]

The MCO shall meet the following geographic access standards for all members, in addition to maintaining in its network a sufficient number of providers to provide all services and Equal Access to its members.

Provider/Service	Geographic Access Standards
PCPs (Adult & Pediatric)	Two (2) providers within forty (40) minutes or fifteen (15) miles
Adult Specialists	One (1) provider within sixty (60) minutes or forty-five (45) miles
Pediatric Specialists	One (1) provider within one hundred twenty (120) minutes or eighty (80) miles
Hospitals	One (1) provider within sixty (60) minutes or forty-five (45) miles
Mental Health Providers (Adult & Pediatric)	One (1) provider within forty-five (45) minutes or twenty-five (25) miles
Pharmacies	One (1) provider within forty-five (45) minutes or fifteen (15) miles
Tertiary or Specialized Services (Trauma, Neonatal, etc.)	One (1) provider within one hundred twenty (120) minutes or eighty (80) miles
SUD Counselors (MLDAC) (Adult & Pediatric)	One (1) provider within forty-five (45) minutes or fifteen (15) miles
SUD Programs (Comprehensive, Outpatient, Methadone Clinics) (Adult & Pediatric)	One (1) provider within sixty (60) minutes or forty-five (45) miles

[19] Ibid., Section 20.2.

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Revision History

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